

# EDWARDS COUNSELING ASSOCIATES

Janette E. Edwards, LCSW

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## CLIENT INFORMATION REVIEW

Client Name: \_\_\_\_\_ Date of Birth \_\_\_\_\_ SSN \_\_\_\_\_

Address: \_\_\_\_\_ Home Telephone \_\_\_\_\_

City: \_\_\_\_\_ State \_\_\_\_\_ Cellphone \_\_\_\_\_

Zip \_\_\_\_\_ Gender: M \_\_\_\_\_ F \_\_\_\_\_ Email Address: \_\_\_\_\_

Marital Status: Single \_\_\_\_\_ Married \_\_\_\_\_ Other \_\_\_\_\_ Student: P/T \_\_\_\_\_ F/T \_\_\_\_\_

If Minor, please list parent(s) name \_\_\_\_\_

Parent's Date of birth and social security number **if different from primary insurance holder**

\_\_\_\_\_

### Primary Insurance

Insured's Name: \_\_\_\_\_  
\_\_\_\_\_ Employer \_\_\_\_\_

Insured's Date of Birth: \_\_\_\_\_ Insured's SSN \_\_\_\_\_

Insurance Company \_\_\_\_\_ EAP (yes or no) \_\_\_\_\_

Policy No: \_\_\_\_\_ Group No. \_\_\_\_\_

Authorization Number \_\_\_\_\_ No of Sessions Approved \_\_\_\_\_

Approved Date Span: \_\_\_\_\_ Customer Service Number: \_\_\_\_\_

Claims Address: \_\_\_\_\_

### Secondary Insurance

Insurance Company \_\_\_\_\_

Policy No: \_\_\_\_\_ Group No. \_\_\_\_\_

Claims Address: \_\_\_\_\_

Customer Service Number: \_\_\_\_\_